Washington State Department of Social & Health Services

MPA Medicaid Purchasing Administration

ProviderOne

Washington's Social and Health Services Provider Payment System

Submitting Paper Claims

Frequently Asked Questions (FAQs)

Last Updated 10/12/2010

Q: How can I print the content of this webinar?

A: The associated PowerPoint with all the links can be located at the following website: http://www.dshs.wa.gov/pdf/provider/Webinar/SubmittingPaperClaims.pdf

Q: If a provider emails our question regarding claims can those claims be paid from that contact via email?

A: The provider relations office does not handle these "contact us" emails. The lead worker in the customer service office stated that if it appears a claim denied in error due to something happening here at DSHS they would send the TCN number back to our claims area for reprocessing. If the email request is to just reprocess claims, we cannot do that and the claims would have to be resubmitted by the provider.

Q: How long is it taking to Process New Core Provider Agreements?

A: The lead worker in the provider enrollment did not have a specific timeframe. They have many to do and hopefully with the phone lines up only until 1 pm this will give them more uninterrupted time to complete them and get caught up.

Q: For dental claims, can we submit a claim electronically and send supporting data thru NEA fast attach?

A: Yes you can submit the claim electronically however we currently cannot receive insurance EOBs or other claim back up thru the NEA fast attach program.
Our Prior Authorization unit are the only staff at DSHS that have access to the NEA fast attach program and they do utilize it to receive supporting documents (X-Rays) to authorization requests.

Q: Where can I get the ProviderOne denial code list?

A: DSHS is currently using the standardized HIPAA denial reasons. These can be found on the following website: http://www.wpc-edi.com/products/codelists/alertservice

Q: If Medicare is primary and pays and Medicaid of WA is secondary, do I leave box 29 blank?

A: Correct. Box 29 is only for a commercial private insurance payment.

Q: I was told that we are no longer supposed to be using the 7 digit provider Medicaid #s on claims and that the taxonomy code should be in #52a, and #56A (not 58) on 2006 ADA?

A: What you have heard is correct. With the implementation of ProviderOne, DSHS has discontinued the use of the old 7 digit provider numbers. The provider's NPI number is replacing that 7 digit number in ProviderOne. The correct fields (boxes) to utilize on the paper ADA form would be:
Box 49 = Group/Clinic NPI number
Box 52A = Group/Clinic Taxonomy code
Box 54 = Servicing/Rendering Provider NPI number
Box 56A = Servicing/Rendering Provider taxonomy code

Q: I am confused with sending in a 2ndry claim electronically. Am I correct in understanding we can put in the comments that the EOB will be sent in or faxed in?

A: I would suggest putting in the comment that your EOB is coming either via fax or through the mail. I only say this due to the fact that sometimes the claims will not be held up for the EOB with only the private insurance information listed on the claim. With a comment the claim will be held awaiting for the EOB to be received and attached, then processed. Again for any information that you may be sending in I would put a comment of what it is. You must enter the TCN of the claim on the correct cover sheet before faxing or mailing the EOB. Get the cover sheets at http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html

Q: How are Medicare crossover claims to be adjusted when there is a change to the Medicare charges?

A: These claims would be adjusted just like any other paid claim. If you would like to adjust these through ProviderOne you can bring up the paid claim and do the adjustment that way. There is a specific webinar on how to adjust claims through the direct date entry (DDE) function in ProviderOne. Go to the following website: http://www.dshs.wa.gov/provider/training.shtml , scroll down the page and open the "Submit Fee For Service Claims (Professional, Dental, Institutional)" section. Continue down the open page until you find the webinar "Adjusting Claims in ProviderOne" and view the recorded webinar.

Q: During the scanning process we have noticed in the DDE that the DOB is incorrect or misaligned. Have you noticed any problems on your end regarding this?

Q: We are getting denials on our claims that only have a 2 digit year, saying DOB does not match?

A: We have not heard of problems with the DOB being incorrect or misaligned. As far as we know if the claim is submitted via direct data entry (DDE) the system requires the 4 digit year to be used or the claim cannot be sent. However if the claim is submitted on paper the scanning system should be able to read either a 2 or 4 digit year. If the birth date you are using is what we have loaded in ProviderOne for the client there should not be a problem. I would suspect that either the birth date is incorrect(in your records or ours) or the birth date you are using does not match with the Client ID number on the claim.

Q: How do I reach you again by e-mail?

A: Currently there are two ways to get in touch with DSHS via email. The first is the "Contact Us" form that is found at the following:
https://fortress.wa.gov/dshs/p1contactus/Provider_WebForm.aspx
The second is through the provider relations unit directly at: providerrelations@dshs.wa.gov

Q: Is there a webinar for direct data entry?

A: Yes there is a webinar for DDE claims. The claim types included are the CMS-1500, ADA 2006 (Dental), and UB-04 (Hospitals). These webinars along with the associated PowerPoint have all been recorded and are available to view at the following website.
http://www.dshs.wa.gov/provider/
Once you log into this site you will want to click on the "Training" tab on the left side of the page. From the "Training" page you will scroll to the bottom of the page and expand the "Submit Fee For Service Claims (Professional, Dental, Institutional)" green arrow. Once this expands the webinars and PowerPoint will be listed about halfway down the list.

Q: Why do claims that show on the EOB as "In Process" never seem to get out of being "In Process"?

A: This could be happening for a couple different reasons. First it could be due to the large volume of paper claims that DSHS currently has in backlog or the claim could be in a specific unit such as the Coordination of Benefits office for them to finalize. If you have a large volume of these claims please send a sample of the in-process TCN numbers to the provider relations office directly and we can see if the claims are being held up incorrectly.

Q: Since there is a delay processing paper claims, how are potential timely filing issues being addressed?

A: When the paper claims are received at DSHS they go through the scanning system. At that time the claims are issued a claim TCN number that will stay with that specific claim throughout its journey here at DSHS. Because of this early issuing of the TCN, timely issues should not be a problem.

Q: If we have Medicare as Primary and Secondary is DSHS, do we need to bill Medicare for A4927 if we already know that they are denied as non-covered? Can we bypass primary?

A: For many of these services that are never covered by Medicare, ProviderOne has been hardcoded to bypass the need to have the EOMB attached. You should be able to bill DSHS directly for these services.

Q: What is the estimated time frame our paper claims will be processed?

A: Currently the timeframe is 45 days or longer. You have the opportunity to submit via direct data entry (DDE) in which the claims are processed much faster

Q: Many of our previously submitted paper claims that date back to last spring through the summer, are continuously coming through on our remit as 'In Process.' When will these finally complete processing?

A: I would submit your questions concerning your in-process claims to our "Contact US" email box and give a couple of the ICN/TCN numbers you have and they will check this out for you and most likely send this over to one of our system analysts. Also let them know that you have many of these claims that are still being held. The link to send in the email is:
https://fortress.wa.gov/dshs/p1contactus/Provider_WebForm.aspx

Q: Do all claim form fields on a paper claim have to be centered?

A: If the fields are needed for the processing of the claim the answer would be yes. The scanning system is very peculiar and if it is off just a little it may not read the information correctly.

Q: If there is handwriting on the claim does it automatically gets rejected?

A: The claim will not automatically be denied, however it will take longer to process as the scanning system will not be able to read the handwriting causing the claim to be manually corrected and then sent to processing. We recommend if possible that the paper claims be printed.

Q: We have noticed paper claims denying with denial codes that appear to be incorrect. For example missing info required to process and denials for other info that is listed on the claims.

A: If you notice this happening my suggestion is to send an email to our "Contact Us" email box with some claim number (TCN) examples. Explain that you are concerned with the error messages being received back. The address for the "Contact Us" form is https://fortress.wa.gov/dshs/p1contactus/Provider_WebForm.aspx

Q: Should 24-I be left blank?

A: This is the ID qualifier field for the servicing or rendering provider NPI and if filled in should not affect the processing of the claim.

Q: When adjusting a claim on line-baby on mom marked yes do we put the mom's last name and date of birth in the more client information field?

A: NO! When billing for a newborn claim using mom's ID, enter the baby's name, baby's birthdate, and the baby's gender in the boxes instead of mom's information.

Q: Is there a special SCI code needed for claims we are billing when the patient does not have Medicare part B coverage? Do we just need to bill Provider One as secondary with the Medicare rejection?

A: If Medicare has denied a service you will need to bill DSHS as primary, but include the Medicare EOMB showing that they did not cover the service.

Q: On line 33, is this the group information or the rendering doctor information?

A: This would be your group NPI and taxonomy information. The rendering provider NPI and taxonomy information would go in field 24J.

Q: What kind of time line should we expect to receive a return answer for emails sent to the contact us email?

A: The goal is two weeks, but they are about 30 days out right now. The Medical Assistance Customer Service Center (MACSC) is catching up quickly because of their new hours! If you are checking limitations on services, the turnaround time is 24-48 hours. PA inquires are 2 weeks.

Q: In box 24A for date of service can we hand write the date of service on claim?

A: Hand written claims are not a preferred way to receive the claims due to the fact that that the scanning system cannot read this information. The year date is accepted in either the 2 or 4 digit format.

Q: In box 30 can we hand write estimated balance on HCFA?

A: Hand writing is not preferred on the claims as the scanning system has a hard time reading handwriting. If you had write on the claim it delays processing.

Q: In box 22 for adjusted claims would I enter the code on my voucher such as - 16 for lacks info needed for adjudication or would I enter the remarks code N288 missing rendering provider taxonomy. Can this information be hand written?

A: There should be no reason to include these type of codes in this field. This field should be filled in only with the adjustment qualifier "7" and the TCN number from the original claim.

Q: I have sent three emails to the "Contact us" email address, with no reply. When will they start to reply to emails?

A: They are working about 30 days out right now. Their goal is 2 weeks and they are getting through the backlog quickly. Please do not send in multiple inquires on the same topic. Duplicate contacts are one of the reasons we have the current backlog. If you are checking limitations on services, the turnaround time is 24-48 hours. PA inquires are 2 weeks

Q: Can the 1500 be in black and white format or does it have to be on the original red and white form?

A: We would prefer the red and white form due to the fact that when the claim goes through the scanning system the red ink is "invisible" to the scanner. If the form has black lines the scanner may pick this up as additional information or it cover parts of your information.

Q: How will the backup for an online claim be matched with the claim? We are getting some denied for not having backup included.

A: The first thing that you need to make sure you are doing is indicating in the comments field that the DDE claim will have an EOB coming either via fax or mail. If this comment is entered the claim will be held for the EOB to reach the department. The bar coded coversheet must include the claim TCN number and when scanned will be attached to the corresponding DDE claim. The cover sheet must be the first page of you document packet.

Q: Our computer system includes a qualifier with the taxonomy code in 33 B. Does this affect processing?

A: This could affect the processing of the claim because it is possible that the scanning system will read the qualifier as part of the taxonomy code and possibly deny the claim for an invalid taxonomy. If the claim doesn't automatically deny for an invalid taxonomy code it would need to be manually corrected causing the delay in processing. DSHS recommends if possible for providers to not include this qualifier on the claims.

Q: If we are billing electronically and there is no Medicare part B, do we bill DSHS as primary or secondary, and if we bill as Primary how are we to include the Medicare EOMB?

A: Bill DSHS primary and if you have the ability you can attach an electronic copy of the EOMB or send it through the mail with a bar-coded cover sheet

Q: On box 24A, will the claim be delayed or denied if the year is listed as 2 digits rather than 4 digits? There doesn't seem to be enough room on the claim form to have 4 digits for the year.

A: We can accept the claim either way, the scanner just likes the 4 digit year better. Your claim will not deny if you only have a 2 digit year.

Q: I'm sorry what is a UB-04 form. I have never heard of it.

A: The UB-04 claim form is used for hospitals and facility billing.

Q: Is a comment required in field 35 when submitting a secondary paper claim to ProviderOne (with EOB)

A: To indicate a payment by a commercial insurance plan, enter the term “Insurance Payment” and then the amount paid by the plan. Attach the insurance EOB to the claim.

Q: If we are unable to edit claims can we hand write in information and will someone be able to read it if scanner cannot?

A: Yes, but that will slow down the processing of your claim.

Q: We used to have to write "Medicare EOB attached" in box 19. Is that still required? The presenter skipped over that very quickly. Thank you. (CMS 1500)

A: Here is a link to a Medicare Crossover memo~ http://hrsa.dshs.wa.gov/Download/Memos/2006Memos/06-05.pdf You do not need to put that comment on your claim.

Q: We have begun to submit some of our DSHS secondary claims by DDE online. When we need to send the primary eob with the cover page, are these claims also taking 45 days to process?

A: For the most part DDE claims are processed faster than paper claims; however these claims with private insurance need to be finalized by our Coordination of Benefits office. Because of this it would depend on the backlog that this office has, but I would think that it should be less than the standard 45 days. Please remember to include a claim note on the DDE claim to indicate that you are submitting the private insurance EOB either via fax or through the mail. This will allow your claim to be held up in the system to have the EOB attached.

Q: For the CMS 1500 form when the claim is for a baby using the mom’s ID, do we use the baby's DOB or mothers DOB?

A: When billing for a newborn claim using mom’s ID, enter the baby’s name, baby’s birthdate, and the baby’s gender in the fields instead of mom’s information. Enter the comment SCI=B in field 19. This information can be located in the DSHS Billing and Resource Guide at the following link on page 70: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide/ProviderOne_Billing_and_Resource_Guide.pdf

Q: In box 19, Can I still hand write managed care if the managed care was primary?

A: It all depends what you mean by managed care. If this is a Healthy Options Plan you should not be billing DSHS secondary. If the managed care is Medicare Part C and is a capitated copayment you would enter "Managed Medicare Capitated Copayment". If it is a non capitated Medicare part C plan then you need to enter "Managed Medicare". If possible this information should be typed rather than handwritten.

Q: For dental claims, if the claim requires more than ten lines for services rendered, is it preferable for claims to be entered at the ProviderOne website, or is it acceptable for two separate electronic claims to be sent for the same date of service?

A: Either way will work.

Q: Is the DDE comment field the same as service notes field?

A: Yes. In the DDE claim for it is called “Claim Note”.

Q: For our DSHS secondary claims our computer system auto enters the total charges, payment and balance after insurance but the balance is not correct because there may be a contractual adjustment. We have to white out the incorrect amount and hand write the correct balance. Will DSHS accept the white out and hand written claims?

A: We do not require the contractual adjustment information. We only need to know what TPL paid and it sounds like your system is printing claims like we want. We do not want white out going through our scanning system.

Q: Is it necessary to write Back Up Attached on the paper claims in box 19 when billing a secondary claim to Provider One and should Back Up be written on the EOB as was done previously with DSHS

A: You do not need to put in these comments.

Q: I called the call center and they spoke with the supervisor in claims and they stated that we had to submit with a "MMDDCCYY" format or claims would be denied. Now you are saying we don't have to?

A: The scanning system prefers the format to be "MMDDCCYY" but we will take it with "MMDDYY". The only issue with the two digit year is that it will hold the claim up for a DSHS worker to correct and put in the correct format.

Q: On every secondary claim sent electronically, is it true you MUST have a comment stating you are sending the EOB electronically in the comment field, when you are submitting/downloading the primary EOB's?

A: We highly suggest that you add a comment/claim note to the electronic claim indicating you are sending the EOB. That way the claim is held until we receive the EOB and can attach it. If the comment is not included you run the risk of your claim going through the system and denying for not having the private insurance information which would then require a rebilling on your end.
However for a HIPAA batch file, if the secondary TPL claim sent electronically is HIPAA compliant with all the HIPAA information listed on the claim we do not require you to send in the EOB with the claim. However we do require this specific comment "**Electronic TPL**" on the claim.

Q: Are we able to submit adjustments on line? We were told by customer service to not use the online claims adjustment. If not where are the paper forms located?

A: You can definitely do adjustments online using ProviderOne! Please see the ProviderOne Billing and Resource Guide at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions starting on page 88. The Guide covers sending in a paper adjustment also.

Q: Do you know if Office Ally allows billing DSHS as secondary?

A: Office Ally is set up in ProviderOne as a clearinghouse and does have the ability to send us your claims. You may want to contact Office Ally to see if they have any restrictions on what they can submit. You also will need to make sure that your provider file is set up to show Office Ally as your clearinghouse.

Q: Do you know what the fax number is to send DDE backup info to?

A: It is 1-866-668-1214

Q: Is the CMS 1500 form the same as the Pharmacy Statement (525-106), if not how do I get the CMS 1500?

A: The CMS 1500 claim for is not the same as the Pharmacy Statement Form. The CMS -1500 form can be purchased online or through office supply stores.

Q: Most of our secondary claims do not have TPL, so this comment seems inappropriate. Have any other providers expressed concern with this? TPL is not synonymous with secondary claim

A: We consider all private insurance TPL. I haven't received feedback from a provider on the way we use this term.

Q: When we first went on ProviderOne, our Medicare crossover claims were denying because the taxonomy codes were not dropping correctly. We are currently billing those on paper with the primary insurance EOB attached. A lot of them, we haven't heard anything and others are denying for the same reason, "M255" missing taxonomy but our claims print the taxonomy codes on them. What shall we do to get those paid?

A: You can submit those electronically without having to attach the EOMB. Please watch our recorded Medicare Crossover webinar at https://www2.gotomeeting.com/register/867809658 This webinar will explain the taxonomy issue you are experiencing and provide lots of great information on crossovers.

Q: What and where do we need to say on the DDE claim submission that we are sending primary EOB backup?

A: You need to indicate this information in the claim notes section of the DDE claim. Indicate with this claim note that the EOB is coming either via fax or in the mail.

Q: We have some claims being paid and others denied for various reasons, but we do not have the NPI and Taxonomy printing in box 32a and 32b. Our charges are for professional fees not facility fees. Is it still required to fill those fields?

A: Only certain services require the information in box 32 of the CMS-1500 to be filled out otherwise it is not required. An example of a service that requires this information would be a sleep study which must be done in an approved sleep study center and field 32a &32b is for reporting this facility information.

Q: If a Doctor is a Sole Proprietor, is it a problem to put the NPI and Taxonomy in both 24 J and in 33 B?

A: This should not be a problem.

Q: Where are we to put the taxonomy code on a Medicare claim so that it transfers to DSHS with the automatic Medicare cross over claim?

A: You would need to contact Medicare for the field where they require the taxonomy code so that it can be crossed to DSHS.

Q: In 24j the taxonomy code is the provider, is the taxomomy code in 32b/33b the same number?

A: In 24J you have the NPI of the rendering provider and their taxonomy code. Field 32 is for the facility (if applicable) and field 33 is for the billing NPI and billing Taxonomy.

Q: As a follow-up to the question: "on every secondary claim sent electronically, is it true you must have a comment stating you are sending the EOB electronically in the comment field, when you are submitting/downloading the primary EOB's?", Does this refer to the comment "ELECTRONIC TPL"? When sending secondary claims via HIPAA Batch file, entering this comment means that the provider does not have to submit the primary EOB either electronically or hardcopy, correct?

A: If you are submitting electronic TPL in a HIPAA batch, then you need to follow the instructions in the ProviderOne Billing and Resource Guide, page 75~ http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html That process does require the note/comment "Electronic TPL". Sending a HIPAA batch claim following these directions does not require the EOB to be sent with these claims.

Q: Can we still use the Pharmacy Statement form for hand billing compound prescriptions or do we need to use the CMS 1500

A: Yes, there is still a pharmacy claim form in the Billing Instructions for pharmacies billing compounds.

Q: What is the fax # to submit paper claims?

A: You can only fax related back up for a claim. You cannot fax actual claim forms to DSHS. If you need to fax back up, you can fax it to 1-866-668-1214. Paper claims need to be mailed to DSHS

Q: How do we verify we have the correct NPI number that matches ProviderOne records?

A: You should know the NPIs that you have and use with ProviderOne - especially the ones that are the pay-to NPI numbers as we would have provided you a domain for that NPI under which you use to log into provider one to submit claims, add users, manage your NPI file, etc. If you think you have an NPI that you use and there is a possiblity that the NPI is not in ProviderOne, I would advise you to contact provider enrollment for assistance. Their number is 1-800-562-3022 ext 16137.

Q: On paper claims where does the rendering taxonomy code get put?

A: In field 24J. There are two areas in 24J for both the rendering provider NPI and the rendring provider taxonomy

Q: How can we submit an ITA claim electronically when you require the RSN cert attached to the claim?

A: If you submit that via Direct Data Entry, you can either print out a cover sheet with the TCN and attach the back up to that and mail it in, or if you have the ability to scan that document and save it to your PC, you can attach that back up electronically to the claim

Q: What identifiers do you need on the backup fax?

A: The cover sheet for the claim back up should have the TCN of the claim you are sending in the back up for so that when it gets scanned into the system, it is routed to the appropriate claim.

Q: Do ambulance claims need a referring or rendering provider attached?

A: If you are billing for ambulance services, we only require the billing NPI and appropriate taxonomy for the ambulance service.

Q: In field 19, we have to add special comments such as "managed medicare", SCI=B, or an ndc number to a charge. These things are required by Medicaid, and yet hold up our claims in processing. How do we circumnavigate this problem?

A: If submitting on paper we still require that information. If you submit electronically via direct data entry, you do not need to indicate things such as managed medicare in the comments field (if you have a non capitated plan), and there is a field to enter the NDC for the service line you are entering so it won't have to go into comments and delay processing.

Q: We're told that claims with information written on them are kicked out of the scanning process and therefore not to write anything on the claim. But then we're told that we have to write things such as SCI=B, "managed medicare", and NDC numbers. This information seems conflicting to me. What happens to a claim that is unable to be scanned because it has writing on it.

A: The scanner has problems reading hand writing and those claims get held up for human review. The information that must be on the claim to process correctly can be typewritten in field 19 not just hand written. Better yet send the claims in via direct data entry for processing.

Q: Do I need a taxonomy for our group as well as my physician?

A: If you bill DSHS with a billing NPI and a rendering NPI on your claim submitted to DSHS, then we will require a billing taxonomy and a rendering taxonomy.

Q: For those of us who will be entering the 21st century shortly (new database) I assume that all these fields would also need to be uploaded via EDI. Is there a place we can go to in order to make sure our claims adhere to your guidelines?

A: The HIPAA companion guide would be a start if you intend to send your claims via electronic batch. Here is the link for those companion guides: http://hrsa.dshs.wa.gov/dshshipaa

Q: What are commercial insurance plans Medicare, Blue Cross?

A: Medicare is not consideed commercial private insurance. We treat Medicare as Medicare which includes Part A, B, or Part C advantage plans. Medicare/Medicaid claims are called cross over claims and if you submit them Direct Data Entry, when the question on the submission screen asks "Is this a medicare crossover claim?" - answer yes, and fill in the fields. Here is a webinar that talks about billing Medicare crossovers to ProviderOne: https://www2.gotomeeting.com/register/867809658

Q: My billing phyician is the same as the rendering physician - is the NPI the same? Is there an NPI for the facility which is the office?

A: If you only have and use one NPI to bill DSHS, then you would only need to submit that NPI and associative taxonomy in the billing NPI and taxonomy fields on the claim. You do not need to restate the same NPI and taxonomy in box 24J.

Q: 17b requires NPI for the PCCM organization. Often I'm not finding the NPI for the PCCM organization on the following website https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. Can you please tell me where I can find NPI for PCCM organizations?

A: You will need to contact the PCCM for their NPI to make sure you have the right one on the claim.

Q: SCI means what and if you have a lab claim where cigna makes a payment do you enter in box 19 SCI=Y=25.00 cigna to show a payment made from the primary carrier?

A: SCI is a scanning designation, when followed by the proper character, identifes what you are indicating on your claim. using that allows the system to identify what your comments are without the need for human intervention. SCI=Y is the code for when the patient is on a spenddown and would not be appropriate for indicating private insurance backup. If you are billing us secondary to a private insurer, indicate the payment in field 29 then attach the EOB to your claim.

Q: We are having to bill many claims by paper because our of problems with the way providerone's scanner reads our claims. for example, the scanner enters the units as part of the charge. our fields are correct by cms standards.

A: All paper claims are scanned. If they are commercially produced claim forms and the data entered is properly centered, there should not be an issue with mis-scanned fields. If you are able to submti via our direct data entry, this would eliminate that scanning issue and the claims will also adjudicate much faster.

Q: We use a clearing house but we are having problems with our SCI comments not reaching providerone. who do we contact to troubleshoot 837 problems?

A: hipaa-help@dshs.wa.gov

Q: In CMS Form, we can enter NDC Code. Is there any valid Format that need to be entered in Form Locator 19?

A: Yes. follow intructions outlined in memorandum 06/06 at the following link: http://hrsa.dshs.wa.gov/Download/Memos/2006Memos/06-06.pdf

Q: Is there any additional information that needs to be entered if DSHS is tertiary?

A: If there is more than one private insurance, you enter their combined payment in field 29. Submit both EOBs.

Q: Where would I enter the Adjustment reason codes from the private insurance on the electronic claim form? I need the equivalent CMS-1500 box to crosswalk it into my software.

A: You would need to check the HIPAA companion guides for the appropriate loops and segments. The link to those guides are at: http://hrsa.dshs.wa.gov/dshshipaa/ If you need further assistance you may contact the hipaa team at hipaa-help@dshs.wa.gov

Q: For an electronic claim form, where do I put the comment "Electronic TPL" ?

A: You will need to place that information where the companion guides indicate. the guide can be found at: http://hrsa.dshs.wa.gov/dshshipaa/ and if you need further assistance you can contact the hipaa help team at hipaa-help@dshs.wa.gov

Q: Can you use SCI=T for billing twins?

A: No. the comment would be 'Twin A" or "Twin B" depending on which twin you are billing for.

Q: Yes...is there going to be a new webinar about electronic billing?

A: Yes. We do have a recorded webinar for billing in ProviderOne via direct data entry at the following link: https://www2.gotomeeting.com/register/399418274

Q: Can we staple attached EOB to paper claim now?
A: DSHS prefers you use a paper clip.

Q: Do they have a webinar scheduled for submitting claims were Medicaid is secondary yet?
A: That webinar for billing DSHS secondary to commercial private insurance is currently in the works and will be posted soon. There is a recorded webinar posted on the website currently that talks about billing Medicare crossovers in ProviderOne. You may find that webinar under "training" on the DSHS provider website at: http://www.dshs.wa.gov/provider/index.shtml

Q: What is the best way to get questions answered about denied claims.. its so hard to get to a real person and some questions can not be answered by the IVR. Email maybe?
A: The fastest method to get assistance with claim issues would be to use the provider "contact us" email. That can be found at: https://fortress.wa.gov/dshs/p1contactus/Provider_WebForm.aspx

Q: Do you use a clearing house as well for electronic claims? If so what is that info pls

A: DSHS does not use a clearinghouse. The DDE feature of ProviderOne enters the claim directly into the system.

Q: OK, however I will not have a TCN # until that claim is denied because it does not have an invoice with the electronic claim I did, we cannot attach an invoice with the electronic claim submittion. Can I get a TCN # RIGHT after I submit the claim off our clearinghouse website? We do not have a scanner yet.[Shari Salinas] [sharis@familyservicegc.net] [Deleted] [Q: 2:42 PM]
A: If you are sending in batch claims and you know that you will have back up for a particular claim, you will need to indicate in claim notes that you have back up pending. Once the claim enters the system, you can do a claim status search to find the TCN to place on the document coversheet and send that in. When it is received , that document will then route to your TCN so that your claim can be finalized.

Q: Do you have any information on billing medicare advantage plans through provider one?
A: Yes. There is a recorded webinar on that topic as well as the powerpoint used and questions and answers related to that webinar. You can access those on our provider website at: http://www.dshs.wa.gov/provider/training.shtml#provider

Q: When submitting a claim to you as the secondary payer and the primary payer didnt pay anthing do we put in box 19 eob attched with 0 payment.
A: Yes. If the client has commercial insurance or Medicare and they denied the service, you can bill us directly for that service but you will need to send in a copy of the EOB attached to demonstrate non-payment from that private insurer or from Medicare

Q: What do I do about 2 dental paper claims that have been submitted incorrectly? I haven't gotten a denial yet.
A: If the claims are not in the ProviderOne system and it has been at least 30-45 days since you sent them in, you may resend the claims. If the claims are in the system but are still in process and it has been over 45 days, you can submit a ticket to the customer service center to have them review why those may still be in process.

Q: Is it necessary to bill DSHS if the patient has a Spend down and has no coverage? The balance after Medicare pays can be transfered to the patient, correct?

A: You would not bill the Department until the spend down has been met and the client becomes eligible.

Q Will DSHS pay the Copay of Commercial insurance such as Secure Horizons?

A We are assuming Secure Horizons is a Medicare Advantage Plan and the Department may pay based on DSHS or Mediare allowable for the service.

Q: Are there copies of this webinar so we have the web site addresses. Icannot copy and paste.

A: You can go to our provider website and under training you will be able to access the recorded webinar as well as a copy of the powerpoint. We will be posting the Questions and Answers soon. The link to the provider website is http://www.dshs.wa.gov/provider/training.shtml#provider .